STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on December 14, 2009 through December 18, 2009, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The census was 108 residents. The sample size was 22 sampled residents, which included 3 closed records. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000	F 000 Please accept this plan of correction as this facilities credible allegation of compliance. The submission of the plan does not constitute an admission that the alleged deficiencies did in fact exist. This document is provided	02-1-10
F 154 SS=E	The following deficiencies were identified: 483.10(b)(3), 483.10(d)(2) NOTICE OF RIGHTS AND SERVICES The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 7 of 22 residents or their legal representatives were informed about the	F 154		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie Nassen — TITLE: Administrator — (X6) DATE: 1/31/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 1	F 154	F 154	02-1-10

risks and benefits of psychopharmacological medications (Residents #4, #5, #6, #8, #9, #11, and #12).

Findings include:

The facility's "Psychopharmacologic Drug Usage" policy, dated 3/04, included the following procedure: "Consent for use of psychopharmacologic medications must be given in writing by the resident or the resident's representative. This consent form will also include the educational components of: name of medication, reason for its use, possible side effects of the medication, and expected outcome of the medication." The policy definition included the following types of drugs: antipsychotropics, antidepressants, antianxiety, sedative, hypnotics and antihistamines.

Resident #8

Resident #8 was admitted to the facility on 8/13/07, with diagnoses including hypertension, history of breast cancer, gastroesophageal reflux disease, thyroid disorder, and depression. Medication orders included Ativan 0.5 mg every day for anxiety. A review of the resident's record failed to provide evidence of a consent for Ativan, and the Director of Nursing (DON) confirmed that the resident had not signed a consent for Ativan.

Resident #8: Written consent now signed with appropriate educational components. No negative outcome.

Resident #9

Resident #9 was originally admitted to the facility on 12/5/07, with re-admission on 7/12/08. The quarterly Minimum Data Set (MDS), dated 12/2/09, indicated that the resident's cognitive status was impaired, with poor decision-making

Resident #9: Written consent now signed with appropriate educational components. No negative outcome.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 2 ability. Diagnoses included hypothyroidism, dementia, and anxiety. Medication orders included Zoloft 100 mg every day for depression and Xanax 0.25 mg every day for anxiety. Record review revealed a consent for Zoloft dated 7/14/08, with "Verbal Consent" written in the Resident Representative's signature line. The DON acknowledged that the resident's representative, who came in daily to the facility, should have signed the consent. The consent for Xanax had been signed on 12/8/07 by the resident, and had not been re-signed when the resident obtained a legal guardian. The DON confirmed that the facility should have ensured that the resident's representative was informed about the risks and benefits of Xanax. Resident #11 Resident #11 was originally admitted to the facility on 7/28/08, with re-admission on 8/17/09. Diagnoses included diabetes, Alzheimer's disease, and depression. Medication orders included the anti-depressant Zoloft 25 mg every day. The consent for Zoloft in the resident's chart did not include a signature by the resident's representative. Resident #4 Resident #4 was admitted to the facility on 7/15/09, with diagnoses including, dementia, debility, generalized pain, and depressive disorder. Medications orders included Paroxetine HCL (Paxil) 20 mg once a day for depression. The medication order was dated 12/5/09. Review of the resident's record failed to provide evidence of a signed consent for the Paxil. The DON later provided a consent form for the resident with	F 154	Resident #11: Written consent now signed with appropriate educational components. No negative outcome. Resident #4: Written consent now signed with appropriate educational components. No negative outcome.	02-01-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 3 documentation of a verbal consent being obtained from the resident's son dated 12/5/09. The consent from did not document the facility staff members who obtained and witnessed the verbal consent. In discussion with the DON, the DON confirmed that in follow-up to verbal consents written consents were to be obtained. The DON agreed when staff obtained verbal consents they should be documented and witnessed. There was not a process in place to ensure verbal consents were followed-up with written consents. Resident #5 Resident #5 was re-admitted to the facility on 3/31/09, with diagnoses including senile dementia with depression, generalized psychosis, anxiety, debility, generalized pain, and pressure ulcer of buttocks. Medication orders included two separate orders for Lorazepam (Ativan) 2 mg/milliter either oral or injection, to be used as needed. The first order was dated 9/21/09, and the second order was dated 10/08/09. A doctor's progress note dated 6/28/09, indicated the resident's condition had worsened, and that Ativan was to be used as needed for anxiety. Resident #5's record lacked evidence of a signed consent for the Ativan. The DON later provided a consent form for the resident with documentation of a verbal consent being obtained from the resident's daughter dated 10/8/09. The consent form did not document the facility staff members who obtained and witnessed the verbal consent. Resident #6 Resident #6 was admitted to the facility on 8/20/09 with diagnoses including Alzheimer's	F 154	Resident #5: Written consent now signed with appropriate educational components. No negative outcome. Resident #6: Written consent now signed with appropriate educational components. No negative outcome.	02-01-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 154	Continued From page 4 disease, debility, depressive disorder, generalized pain and anxiety. Medication orders included Lexapro 10 mg daily for depression, which was dated 11/20/08. Review of the resident's record failed to provide evidence of a signed consent for the Lexapro. The DON later provided a consent form for the resident. The form was dated 11/20/08. The form was not signed and there was no documentation that an interim verbal consent had been obtained. Resident #12 Resident #12 was admitted to the facility on 3/6/09, with diagnoses including agitation, dementia, nonorganic psychosis, and depressive disorder. Medication orders included Depakote 250 mg twice a day for behavior management, the order was dated 6/3/09; antidepressant Remeron 15 mg. three times a day which was dated 11/18/09; and Seroquel 25 mg for psychosis and depression which was dated 3/30/09. Resident #12's record lacked evidence of a signed consent for the Depakote, Remeron or Seroquel. The DON later provided consent forms for the resident with documentation of a verbal consent being obtained from the resident's son for the Depakote dated 6/8/09, and two different verbal consents for Seroquel dated 3/30/09. There was no consent form for the Remeron. The verbal consent forms lacked the facility staff members who obtained and witnessed the verbal consent.	F 154	Resident #12: Written consent now signed with appropriate educational components. No negative outcome.	02-01-10
F 164 SS=B	483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY The resident has the right to personal privacy and	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 5 confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to protect the confidentiality of the medical information of the facility's residents. Findings include: During an observation on 12/15/09, of the breakfast meal time in the 200 Hall dining area, it was observed that there was a piece of paper	F 164	F 164 All Residents have the potential of being affected. All staff will be re-educated on protecting the confidentiality of medical information for all Residents. D.O.N. or Designee will audit daily transport appointment list to assure Residents medical information is kept confidential. D.O.N. will present audit at monthly QA meeting for 3 continuous months. Administrator to monitor.	02-1-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 6 lying on the counter of the cabinet area. The paper had a list of various residents in the facility and the appointment times of the residents for the day. The data included the appointment times and the names of the physicians. The paper could be easily read by anyone present in the area.	F 164		02-1-
F 204 SS=D	483.12(a)(7) ORIENTATION FOR TRANSFER OR DISCHARGE A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to provide adequate orientation that ensured a proper discharge for 2 of 22 residents (Resident #2 and #13). Findings include: Resident #2 Resident #2 was admitted to the facility on 6/20/09. Diagnoses included diabetes mellitus, sleep apnea, and anxiety. She had lived in another nearby community with her husband until he was no longer able to care for her. It was Resident #2's hope to return to her home and husband. Review of the record and resident interview revealed she was to be discharged home in two days. The last social services note dated 12/12/09, stated that Resident #2 "will be discharging to home on 12/18/09. SW(social	F 204	F 204 Resident #2: Resident was discharged on 12/19/09 with Home Health and Physical therapy. All necessary equipment was provided. No negative outcome. Resident #13: Resident's careplan updated to reflect possible discharge to Assisted Living, with transition approaches in place to monitor Resident's ability to thrive in a more independent setting. All Residents have the potential to be affected. Social Worker will be re-educated on the need to provide sufficient preparation and orientation to Residents to ensure safe and orderly discharge from the Facility. D.O.N. will present audit at monthly QA meeting for 3 continuous months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 7 worker) to have services in place to provide for safe discharge." The entry did not entail what services or what preparations were being provided or how the resident and her husband were being prepared for the discharge. In an interview on 12/16/09 with Employee #5, the Social Worker, it was stated that "she thought that she had written a more recent detailed note." That note could not be produced at the time of the interview. Resident #13 Resident #13 was admitted to the facility on 2/18/09, with diagnoses including uncomplicated diabetes mellitus, brain injury, abnormal gait, presenile dementia, and depression. Review of the resident's records revealed a legal guardian had been awarded; the resident had been recovered from brain injury; and since admission to the facility the resident had been receiving therapy and greatly improved. On 12/14/09 in the afternoon, Resident #13 was observed ambulating independently returning to the Garden Court (secure/locked) unit. The accompanying charge nurse on the tour commented that the resident had originally been in an almost coma state when she was admitted and recovered. The facility now planned to transfer the resident to assisted living in January 2010. The nurse indicated the resident was hesitant about making the move and got a little nervous when discussing it. Upon introduction, Resident #13 was alert and oriented. The resident spoke clearly, appropriately expressed herself and answered	F 204		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 204	Continued From page 8 questions appropriately. The resident was neat in grooming and dress. On 12/13/09, administrator, Employee #1, confirmed Resident #13 had made great strides and was identified for alternate placement in the facility's assisted living which was scheduled to open January 2010. The administrator indicated that the guardian was in agreement with plans for alternate placement. Resident #13's care plan, care plan meeting notes, social services notes, assessments, nursing and physician progress notes, and other documentation lacked evidence of identification nor addressed plans for discharge. On 12/17/09 in the afternoon, the facility's social workers (Employee #3 and #4) confirmed Resident #13's concerns and possible adjustment issues with changes in living arrangements had not been identified or addressed. The social workers also confirmed that no preparations were made for transitioning Resident #13 to assisted living.	F 204		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 9 o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to post on a daily basis the resident census, the number of licensed and unlicensed staff available for each shift and the actual number of hours that each category of staff would be working. Findings include: Upon initial entrance on 12/14/09 at approximately 3:00 PM, the posted staffing and resident census information had not been changed since 12/11/09. The necessary and required data was not updated until 12/17/09.	F 356	F 356 Facility has current posting of Facility Name Current Date Total number of actual hours worked for RN's LPN's CNA's And Resident Census. All Residents have the potential of being affected. Facility recognizes the importance of the Resident assurance of adequate staffing on a daily basis. Human Resource Director re-educated on the necessity of posting daily staffing and census information. Administrator or Designee will audit 3 x weekly x 3 months to assure accurate and current information is posted daily. Administrator will bring results of audit to monthly Q.A. meeting for 3 continuous months. Administrator to monitor.	02-1-10
F 361 SS=D	483.35(a) DIETARY SERVICES - STAFFING The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.	F 361	D.O.N. will present audit at monthly QA meeting for 3 continuous months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 361	Continued From page 10 If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure its Food Service Supervisor received frequently scheduled consultation from their Consultant Dietitian. Findings include: A review of dietary service activities on 11/16/09 revealed that the Food Service Supervisor (FSS) had been making changes to the corporate menu in response to resident food preferences, but the facility's Dietitian had not been reviewing the modifications. According to the facility's "Menu Planning" policy, dated 7/08, "The Food Service Supervisor, in conjunction with the Consultant Dietitian, will be responsible for planning seasonal entrees selective four to six-week menu with modifications of the different diets prescribed....If substitution is needed for some reason, it will be recorded as outlined in the substitution book." The FSS confirmed that the Dietitian was not	F 361	F 361 All Resident's have the potential to be affected. Food Service Supervisor and Consultant Dietician have been re-educated on job descriptions and duties. Consultant has reviewed current menu and will sign weekly upon review. Food Service Supervisor to consult with Dietician on any changes to planned menu. Substitutions will be placed in notebook for Dietician review. Administrator will audit substitution book and menu weekly x 3 months to assure consultant dietician is working in conjunction with Food Service Supervisor for planning seasonal entrees and modifications of different diets. Administrator will bring results of audit to monthly QA meeting for 3 continuous months. Administrator to monitor.	02-1-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 361	Continued From page 11 reviewing the modified menus, and that substitutions were being recorded in a substitution book. The facility's job description for the Consultant Dietitian was reviewed, and it included the following duties: 1) Ensure the accuracy and adequacy of modified diets as planned and served; 2) Evaluate sanitation and safety and procedures of food handling as necessary and required; and 3) Plan and conduct in-service and educational programs for Food Service personnel, as well as all staff when indicated. An interview conducted with the Dietitian on 11/16/09 at 10:30 AM, revealed the Dietitian was not involved in reviewing menus, overseeing sanitation and food handling procedures, or conducting in-services for kitchen staff. The Dietitian also acknowledged that she was unaware of the recent (10/14/09) kitchen inspection results.	F 361		
F 371 SS=F	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interviews, the facility failed to ensure food was	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 stored and distributed under sanitary conditions. Findings include: A tour of the facility's main kitchen and four satellite kitchens on 11/14/09 at 3:30 PM revealed the following: Inadequate sanitizing: 1) There was an inadequate amount of sanitizer in the dishwashing machine. The Food Service Supervisor (FSS) explained that a new sanitizing system had been installed three weeks earlier, and that it had been inspected a week earlier by a contracted maintenance company. On 11/15/09, the maintenance company re-checked the system and discovered that faulty tubing was preventing the sanitizer from being added to the machine. The FSS acknowledged that the pH of the water was not being monitored by kitchen staff; 2) A test of the pH of the wiping cloth bucket solutions revealed an inadequate amount of sanitizer. Outdated foods: The main kitchen's refrigerators contained the following: a pan of roast beef dated 12/8; two bags of sliced potatoes labeled "use through 12/9/09;" an opened container of vanilla yogurt labeled "best by 11/18/09;" a pitcher of prepared calorie supplement dated 12/7; a pitcher of grape juice dated 10/28. In the 200 Hall kitchen, a pitcher of grape juice was dated 11/19. The FSS indicated that prepared and opened potentially hazardous foods were to be discarded after three days; however, a written policy addressing this timeframe was not available. Undated foods: The main kitchen's refrigerators contained the following undated foods: an opened container of vanilla yogurt; re-wrapped ham;	F 371	F 371 All Resident's have the potential to be affected. Food Service Supervisor and staff will be re-educated on procuring food from sources approved or considered satisfactory by Federal, State or local authorities and to store, prepare, distribute and serve food under sanitary conditions. D.O.N. or Administrator will audit main kitchen and 4 satellite kitchens weekly x 3 months to assure food is stored, prepared and distributed and served under sanitary conditions. D.O.N will bring results of audit to monthly QA meeting for 3 continuous months. Administrator to monitor.	02-1-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 prepared ranch dressing; prepared calorie supplement. In the 100, 200, and 300 Hall kitchens, bags of cut cantaloupe, containers of resident leftovers, and opened jugs of milk were undated. Improperly stored scoops and wiping cloths: In the main kitchen, scoops were being stored in large bags of farina and powdered milk, and wiping cloths were being held on counters rather than in buckets.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 14 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and staff interview, the facility failed to ensure safe and proper storing of drugs and biologicals. Findings include: On the morning of 12/17/09, an observation of the facility's medication room, treatment cart and 200 Hall Medication cart was made. The following was found: 1) One bottle of house stock Guaifenesin 400mg had been opened and dated 3/23/09, and returned to house stock shelves. 2) House stock bottles of Multi Vitamin with dispense date of 7/23/09 and Folic Acid with dispense date of 10/13/09, these items had been dispensed by the facility's pharmacy in retail type dispensing of brown bottle with non-child proof lids, there was concern that the items were on the house stock shelves and there was no way to determine if they had been opened or compromised in any way since there was not any type of seal. 3) An unlocked and unmarked cupboard contained a large volume of multiple individual resident's unit dose packaged medications. 4) There was a locked, unmarked cupboard with multiple narcotic medications awaiting	F 431	F 431 All cupboards labeled appropriately. All over the counter medications are dated with date of opening. Narcotic medications waiting to be destroyed now labeled as such. Treatment cart now organized by units to assure the potential for missed medications and potential for cross contamination does not occur. Resident's medications that have been brought into facility are now stored in appropriate cupboard and labeled as such. The orange superior extra/emergency medications do now have a list of what medications are stored in it. Pyxis company superior will send a list of all medications available in Pyxis.	02-1-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 15 destruction. 5) The facility's treatment cart had one bottle of Hydrogen Peroxide and Sterile Water both of which had been opened and were not dated; all of the facility's residents ointments were randomly stored and intermingled in a drawer which lended to the potential for missed or unaccounted items, as well as a potential for cross contamination; several of the drawers were soiled with unidentified substances. 6) The 200 Hall med cart had several house stock items which had been opened and were not dated which included Milk Of Magnesia, Antacid Regular Strength liquid, Senna Laxative, Cranberry Juice Extract tablets, Oyster Shell Calcium 500 milligram with Vitamin D and Iron tablets; loose house stock, single package Gas X-tabs and Ultra Fiber Tab were not kept in the original manufacture's packaging which contained the lot numbers and expirations dates; there was a plastic bag with six to eight different medications to be returned to the resident's home/family which was stored in one of the drawers on the cart. 7) One multi dose vial of Aplisol in the refrigerator, used for resident and staff tuberculosis skin testing, was opened and not dated. 8) There was a cart (PYXIS/AMDS (Automated Medication Dispensing System)) with emergency medications and a separate box of emergency antibiotics, but there was no listing of the available medications kept on cart or box. During the 200 Hall med cart observation, Licensed Practical Nurse (LPN) (Employee #8), identified the bag of medications, being stored on the cart were being stored there until the family came in to pick the medications up to take them	F 431	Continued: F 431 All nursing will be re-educated on the necessity of labeling in accordance with accepted professional principles. All drugs and biological must be dated upon opening. Resident's medications must be placed in cupboard labeled as such. Narcotic cupboard must be labeled also. D.O.N will audit 1 med cart weekly to assure all OTC meds are labeled with date opened x 3 months. D.O.N will bring results of audit to monthly QA meeting for 3 continuous months. Administrator to monitor.	2-1-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 home. The LPN stated she was not aware if there was a designated area in the medication room for this purpose. The LPN stated that it was the facility's policy to date house stock items when they were opened. An interview with a second LPN (Employee #9), also indicated it was the facility's policy to date house stock item when they were opened. Immediately following the medication room observations, the Director of Nursing (DON) (Employee #2) was interviewed and acknowledged the medication room findings. The DON stated it was the facility's policy to date house stock items when they were opened, that medications designated to be returned to home should not be stored on the med cart and that there should be an identified area for storage of such items in the locked medication room. The DON further acknowledged that areas/cupboards used to store return, expired or meds awaiting destruction should be clearly labeled and secured. On the afternoon of 12/17/09, the DON provided a copy of the facility's Nursing/Pharmaceutical Procedures, Policy No: 3.17 which was dated 12/06. Review of the policy failed to address dating of open house stock items. In discussion with the DON, the DON acknowledged the importance of having a written policy for staff to reference.	F 431		
F 441 SS=D	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 17 disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to provide for the sanitary storage of equipment. Findings include: Storage of Equipment During a tour of the facility on 12/14/09, a scoop was observed laying directly on the ice in the ice machine.	F 441	F 441 Ice Scoop has been placed in designated container. Staff has been re-educated on infection control issues. All Residents have potential to be affected. Daily monitoring of ice scoop by Kitchen supervisor to assure scoop is in proper position. Results of monitoring will be brought to monthly Q.A. meeting for 3 x monthly. Administrator to monitor.	~~02-1-10~~
F 497 SS=C	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 497		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295078	A. BUILDING _____ B. WING _____	12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR OF ELKO	2850 RUBY VISTA DRIVE ELKO, NV 89801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 497	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on personnel record review and staff interview, the facility failed to conduct annual performance evaluations on 3 of 3 Certified Nursing Assistants on an annual basis (Employee #10, #12, and #14). Findings include: Review of the personnel records for Employees #10, #12, and #14 was conducted. All the employees were Certified Nursing Assistants (CNAs) and had been employed from six months to three years. None of the employees records contained any employee evaluations. In an interview with Employee #16 from Human Resources on 12/17/09, it was disclosed that the facility had no policy addressing employee evaluations. Federal regulations require that evaluations are to be completed at least every twelve months for CNAs. The outcomes of these evaluations should be utilized in determining the types of inservice programs provided by the facility for their CNAs.	F 497	F 497 Employee #10: Annual performance evaluation has been completed. No negative outcome. Employee #12: Annual performance evaluation now done. No negative outcome. Employee #14: Employee is no longer employed. No negative outcome. Human Resources Director will be re-educated on obtaining performance evaluations done upon hire and annually thereafter. All performance evaluations will be done annually and in-services will be provided based upon outcome of evaluations. Administrator will audit 10 employee files to assure performance reviews are being done timely and effectively. Results of audit will be reported in monthly QA meeting for 3 continuous months. Administrator to monitor.	~~02-1-10~~